STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING 00 B. WING	09/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN46107

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F0000	This visit was for the investigation of complaint IN00095190 and IN00095409. This visit was done in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on August 1st, 2011. Complaint IN00095190 Substantiated, Federal/State Deficiencies related to the allegations are cited at F 323. Complaint IN00095409 Substantiated, Federal/State Deficiencies related to the allegations are cited at F 174. Survey dates: September 8th and 9th, 2011 Facility number: 000029 Provider number: 155072 AIM number: 100275200 Survey team: Leia Alley, RN, TC Marcy Smith, RN Patty Allen, BSW Courtney Mujic, RN Karina Gates, BHS Census bed type: SNF: 15	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 107 Residential: 14 Total: 136 Census payor type: Medicaid: 74 Medicare:23 Other: 39 Total: 136 Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 9/14/11 Cathy Emswiller RN			
F0174 SS=D	The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. Based on observation and interview, the facility failed to provide an accessible location where residents could use the telephone in private. This affected 1 of 1 residents reviewed for access to a telephone in a sample of 14. Resident B. Findings include: The clinical record for Resident B was	F0174	F 174 Right to Telephone Access with Privacy This provider ensures that the resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Cordless phones are in the process of being purchased and will be available for residents	09/30/2011

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	reviewed on 9/8/11 at 12:00 p.m. Diagnoses for Resident B included but were not limited to, dementia with agitation, adjustment disorder, depression, chronic anxiety, and delusions. During an observation on 9/8/11 at 12:30 p.m., of Resident B while she was in her room, no telephone was seen anywhere in the residents room. During an interview with the DNS on 9/8/11 at 1:30 p.m., she indicated the facility had moved the area in which residents can place a private phone call. She indicated it used to be in an office on the residential side of the building and was moved into the "Model" room on the residential side of the facility. During an interview with the E.D. (Executive Director) and DNS (Director of Nursing Services) on 9/8/11 at 4:45 p.m. they indicated the family for Resident B calls into the facility to speak with her in the evenings. The DNS indicated staff have to get the resident up into a wheel chair and bring her to the nurses station to talk to the family member, and sometimes the process takes a few minutes and the family member will hang up.		upon installation.Phone in activity room will be available for resident use until cordless phones are installed.Staff inserviced to provide Resident B privacy when making or receiving a phone call. POA of Resident B was contacted 9/22/11 and continues to decline an active phone be placed in resident's room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Residents that reside in the facility are at risk for the deficient practice. Cordless phones are in the process of being purchased and will be available for residents upon installation.Phone in activity room will be available for resident use until cordless phones are installed.Staff inserviced to provide Resident B privacy when making or receiving a phone call. POA of Resident B was contacted 9/22/11 and continues to decline an active phone be placed in resident's room. What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur. Staff to be inserviced regarding accessibility of a phone for private use by the residents on or before 9/30/11 by Staff Development Coordinator or designee. Signage posted conspicuously throughout the building in regards to the availability of a phone for private	

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	During a tour of the facility on 9/8/11 at 10:30 a.m. it was observed that to get to the Residential side of the building, a resident or visitor would have to request assistance from staff, gain access to the coded doors or both. During an interview with the DNS on 9/9/11 at 1:15 p.m., she indicated she was mistaken. She indicated Resident B had a telephone in her room and she did not have to go to the nurses station to talk to family members if they call. During a second observation of Resident B's room, with LPN #1, on 9/9/11 at 1:35 p.m., no telephone was located in the Resident's room. During an interview at that time, LPN #1 verified there was nothing in the phone jack, and she was not aware of Resident B having a cellular phone, and that she did not see a phone anywhere in the residents room. During a third observation of Resident B's room on 9/9/11 at 1:42 p.m., a member of the maintenance team was observed installing a telephone in Resident B's room. During an interview with the E.D. on 9/9/11 at 3:00 p.m. he indicated the member of the maintenance team had left for the day. The E.D. also indicated he		use. Cordless phones will be purchased and made available to the residents in the facility. Timeframe for obtaining the cordless phone is contingent on the manufacture's delivery time. Activity staff to inform residents of the location of the phone available to them.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. CQI tool "Privacy and Dignity" will be completed weekly times 4, monthly times 2, and quarterly x 2. If deficiencies noted, an action plan will be developed and implemented. DNS or designee is responsible for monitoring compliance. Any findings will be brought to the QA team on a monthly basis.	

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	was not sure of the maintenance person's name, but that it was " T something". The E.D. indicated that the maintenance person who installed the telephone over heard a conversation and thought Resident B was supposed to have a telephone in her room, so he took it upon himself to install one for the resident. The E.D. also confirmed that Resident B did not at any time have a telephone in her room. This Federal tag relates to Complaint IN00095409. 3.1-3(f)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview the facility failed to ensure adequate supervision and interventions were used to prevent an accident for 1 of 3 residents reviewed for having adequate accident prevention measures in place in a sample of 14. (Resident #A) Findings included: The record of Resident #A was reviewed on 9/8/11 at 12:00 p.m.	F0323	F 323 Free of Accident/Hazard/Supervision/Devices The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. What corrective	09/30/2011

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	Diagnoses for Resident #A included, but were not limited to, arthritis, dementia, chronic pain, Bipolar 2, depression and restless leg syndrome. A "Resident Assessment," received from the Executive Director (E.D.) on 9/9/11 at 3:50 p.m., was completed on Resident #A on 6/28/11, prior to her admission to the facility. During an interview at this time the E.D. indicated the assessment was done by the facility's corporate nurse liaison while the resident was still in the hospital. The Resident Assessment indicated "...Current Problems/Reason for Placement...Pt. [patient] [with] Bipolar 2 [diagnosis]...confusion...anxiety. Pt is very impulsive - has sitter & will get up - she is unsteady on feet [at] this time...Medical History...extensive psych [history]...Comprehension-Thinking/Awareness...Alert et oriented to: person...confused...Restraints Y [yes] Type: Sitter...Overestimates abilities Y [yes]...Bed alarm Y[yes] .hallucinations...very impulsive... [increased] fall risk...Pt. gets up on own...Still [with sitter 6/2...(rest of date illegible)..." Resident #A was admitted to the facility on 7/1/11 at 6:30 p.m. She was discharged to a hospital on 7/5/11 at 7:40		action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident A no longer resides in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who reside in the facility are at risk for the alleged deficient practice. Residents at risk for falls will have a fall risk assessment completed upon admission. What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur. All resident pre-admission assessments will be reviewed, prior to admission, by the Executive Director, Director of Nursing and the Business Office Manager for acceptance. Staff inserviced on Fall Management on or before September 30, 2011 by Staff Development	

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	p.m. Review of a facility "Nursing Admission Assessment," dated 7/1/11 at 6:30 p.m. indicated Resident #A was "friendly," answered questions "readily," was oriented to "person," had "Clear Speech" "Lower Body Weakness" and "Involuntary Movements." Review of a "Fall Risk Assessment" for Resident #A, completed 7/1/11, indicated she had a history of falls in the last 3 months, had impaired balance, had a history of non-compliance, was confused/disoriented and was "at risk for experiencing a fall." Review of a Pain Assessment for Resident #A, completed 7/1/11, indicated she was currently experiencing pain in her left shoulder. This pain was described as moderate, frequent, aching, increased by movement and decreased by "pain meds." [medications] An undated, unsigned "Interim/Admission Nursing Care Plan" indicated a problem of "Fall Risk related to BLE [bilateral lower extremity] weakness and meds." The goal was Resident #A would have no injury related to falls. Interventions included observing for fall risk contributors, reminding to use call light,		Coordinator or designee. Resident's fall assessment is completed on admission, readmission, quarterly, annually and with significant changes. Residents at risk for falls will have care plans in place and will be updated quarterly, annually and with significant changes. Staff re-educated to notify DNS or designee of all falls. At the time of notification the nurse and DNS or designee will conduct a root cause analysis to determine the most appropriate intervention to be put into place to prevent further falls. IDT will review all falls the following business day and interventions will be put into place to ensure safety and update as necessary. Staff will be inserviced by Staff development coordinator on assessing for pain on or before 9/30/11.Pain assessments will be reviewed for accuracy and updated as needed.Pain care plans will be reviewed for accuracy and updated as needed. How the	

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	provide assistance for transfers and providing appropriate assistive devices. The care plan also indicated a problem of pain related to "old L [eft] shoulder injury. A goal was the resident would have no pain. Interventions included "Meds as ordered..." Resident #A's admission medications on 7/1/11 included Seroquel (an antipsychotic medication for treatment of schizophrenia and bipolar disorder) 300 milligrams (mg) 2 times per day, Clonazepam, (a medication for treatment of seizures and panic disorder) 0.25 mg. 3 times per day and Cymbalta (an antidepressant) 30 mg. per day. Review of nurses' notes for Resident #A for 7/1/11 at 10:30 p.m. indicated the resident was "very confused" and "staff to anticipate wants and needs...PSA [personal safety alarm] in place and functioning...Res[Resident] very restless..." Review of nurses' notes for 7/2/11 at 1:20 a.m. indicated "...very confused...clear speech, unable to clearly voice needs. Res up in w/c [wheelchair] at nurses' station due to resident trying to climb over bolsters in bed...Safety alarms in place and functioning..."		corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. CQI tool “Fall Management” will be completed by Director of Nursing or designee weekly x 4, monthly x 2 and quarterly X 2. If a deficiency is noted, an action plan will be developed and implemented. Any findings will be brought to the QA team on a monthly basis.	

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	Review of nurses' notes for 7/2/11 at 10:00 a.m. indicated "Res very confused, non cooperative, combative [with] care...constantly trying to stand up in chair...res c/o [complains of] pain while res arm was being moved... Review of physician orders dated 7/2/11 indicated Resident #A could receive Ativan (an antianxiety medication) 0.5 mg every 8 hrs PRN (as needed) and Vicodin (a narcotic pain medication) 5/500 mg 1 or 2 tablets every 4 hours PRN. Review of nurses' notes for 7/2/11 at 10:00 p.m. indicated Resident #A had been up much of the day, was "non cooperative [with] care. New PRN meds have been helpful. Res has taken naps occasionally after PRN Ativan 0.5 mg and Vicodin 5/500 mg given." Review of nurses's notes for 7/3/11 indicated Resident #A "restless. confused. Has activated PSA multiple times...attempted to climb out of bed x 3. In wheelchair at nurse's station at this time. Requiring constant reminders per staff to stay seated." Review of nurses' notes for 7/3/11 at 10:00 a.m. indicated "...Several attempts during hour to get up...Requires 1 on 1 assist or constant attendance at all times			

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	[with] toileting, meals or just being around other res [related to] res behavior." Review of nurses' notes for 7/3/11 at 10:00 p.m. indicated "Res woke up, got out of bed and went to toilet in next room. Res was redirected back to her own room..." Review of a nurse's note for 7/4/11 "@ noc" [at night] indicated "Resident is continued on 1:1 care @ nurses' station..." Review of nurses' notes for 7/4/11 at 11:20 a.m. indicated "...Resident restless and confused. Res [up] on night shift and still [up]....was put down 3 different times but refused to stay in bed..." Review of nurses' notes for 7/4/11 at 10:00 p.m. indicated "Has required constant one on one supervision...undressing in hall. Attempting to eat trash from trash can. Touching other residents...orders received...for Haldol (an anti-psychotic medication) 5mg... every 6 hours PRN severe anxiety or agitation; administered...ineffective. Remains at side of staff." Review of nurses' notes for 7/4/11 at 10:45 p.m. indicated "Sat on floor in front of chair. Witnessed per staff. No			

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	apparent injuries. Returned to chair without incident...remains agitated..." Review of nurses' notes for 7/5/11 at 3:20 a.m. indicated Resident #A was complaining of chest pain and inability to breathe. The physician was notified and she was sent to a local hospital emergency room. Review of a nursing note written by RN #1 On 7/5/11 at 3:00 p.m. indicated resident returned from the emergency room with no new orders. "Res confused and agitated. Requires 1:1 care...continuously trying to climb out of bed or [wheelchair]...Spouse currently sitting [with] res." There was no documentation in Resident #A's record to indicate she was assessed or medicated for pain, anxiety or agitation after her return from the hospital on 7/5/11. Review of nursing note written by RN #1 on 7/5/11 at 7:40 p.m. indicated "Res fell out of [wheelchair] at 7:00 p.m. [with] lap attached. Landed on [right] arm...[right] temple at eye brow swollen et purple... [MD] advised to send to [hospital]..." During an interview with RN #1 on 9/8/11 at 1:35 p.m. she indicated Resident #A			

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	was in the "little dining room" around 7:00 p.m. on 7/5/11 in her wheel chair with her lap try on. She indicated no one else was in the dining room. The resident was alone in the dining room. She indicated Resident #A was always "very agitated" and "constantly moving." She indicated the resident "didn't communicate, she just thrashed." RN #1 indicated she (RN #1) was standing outside the dining room "maybe 6 feet away." She turned away and when she looked back at the resident again the wheelchair was tipped over. She indicated the lap tray and the resident were still on/in the wheelchair. She indicated the resident had a lump on the right side of her head. During an interview with the Director of Nursing (DON) on 9/8/11 at 5:30 p.m. she indicated the facility would not have accepted Resident #A if they had known she required 1:1 care because "we don't have staffing for that." She indicated 1:1 care meant someone was with a resident constantly. Further information was requested from the DON at this time regarding a schedule of who was assigned to Resident #A for 1:1 care. She indicated she was not able to provide this information because the assignments were not written out. She indicated Resident #A did not always require 1:1 care, just			

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	"sometimes" but she did not have any scheduled assignments for this. Review of a local hospital's records, obtained by the facility and received from the Assistant Director of Nursing on 9/8/111 at 5:00 p.m. indicated after Resident #A was admitted to the hospital on 7/5/11, she had an MRI (x-ray) of the brain on 7/7/11 "which showed a probable contusion involving the high right frontal lobe." A neurology consultation note, dated 7/6/11, indicated the physician had spoken "to 1 of the nurses there [the facility] and she tells me the patient has been quite combative and agitated since she has been there, requiring 1-on-1 care, which they really cannot provide for her....sent to our emergency room after she fell out of her wheelchair, striking her head. The nurse at the extended care facility told me she did not pass out, she did not seize, she was just agitated and trying to get out of her wheelchair when she fell..." The hospital records indicated Resident #A had to have a feeding tube placed due to poor intake by mouth. A physician consultation note for the feeding tube dated 7/21/11 indicated "...admitted from ECF after she flipped her wheelchair and hit her head. MRI showed a contusion. Subsequently she has had seizures and tremors. She has been encephalopathic. [refers to brain			

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	disease] She does not respond except by opening her eyes. She does not follow any commands. She is nonverbal..." During an interview with Resident A's husband on 9/8/11 at 2:00 p.m. he indicated Resident #A passed away on 9/7/11. This federal tag relates to Complaint IN00095190. 3.1-45(a)(2)			